## ATTACHMENT 6

## Sample CMS 1500 claim form for HealthCheck services

(Physician, physician clinic, physician assistant, or nurse practitioner performed a comprehensive HealthCheck screen with referral and follow-up visit)

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PICA		HEALTH INS					PICA		
HEALTH PLAN BLK LUNG			R 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)						
(Medicare #) (Medicaid #) (Sponsor's SSN)		(SSN) (ID)	1234567890						
. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM   DD   YY	SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)			al)				
Recipient, Im A.	02   10   02 M								
. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP 1	TO INSURED	7. INSURED'S ADDE	RESS (No., Stre	et)				
609 Willow St	Self Spouse Chil	d Other							
ITY	STATE 8. PATIENT STATUS		CITY	***			STATE		
Anytown	WI Single Married	Other							
IP CODE TELEPHONE (Include Ar	rea Code)		ZIP CODE	Т	ELEPHON	E (INCLUD	E AREA CODE)		
55555 (xxx) xxx->	Employed Full-Time			( )					
OTHER INSURED'S NAME (Last Name, First Name, Midd		Student	11. INSURED'S POL	ICY GROUP OF	R EECA NI	IMPED			
•			11. 110011250702	.io i di looi oi	TILOAN	JWIDEN			
OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENTS (CLIBBEN)	TOP PREVIOUS	- INCLIDEDIO DATE	OC DIDTH					
OTTENTIONED OF GEOF OF GROOT HOMBEN		a. EMPLOYMENT? (CURRENT OR PREVIOUS)		a. INSURED'S DATE OF BIRTH SEX					
OTHER INCHIRENCE DATE OF SUPTLE	<del></del>	YES NO		M F					
OTHER INSURED'S DATE OF BIRTH SEX		b. AUTO ACCIDENT? PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME					
M F		NO							
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	-	c. INSURANCE PLAN NAME OR PROGRAM NAME						
	YES	YES NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
			YES NO <i>If yes</i> , return to and complete item 9 a-d.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment			payment of medical benefits to the undersigned physician or supplier for						
below.	nt benefits either to myself or to the party who acce	epts assignment	services describe	d below.					
0.04.55									
SIGNED DATE			SIGNED						
14. DATE OF CURRENT: ILLNESS (First symptom) OR IS, IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.  MM   DD   YY INJURY (Accident) OR GIVE FIRST DATE   MM   DD   YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM   DD   YY  MM   DD   YY						
▼ PREGNANCY(LMP)			FROM TO						
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM   DD   YY						
			FROM		то	IVIIVI   L	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
RESERVED FOR LOCAL USE			20. OUTSIDE LAB?		\$ CHA	RGES			
			YES	NO		- 1			
. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RI	ELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LIN	E) —	22. MEDICAID RESU	JBMISSION					
1 V20.2			CODE ORIGINAL REF. NO.						
<u> </u>	3	'	23. PRIOR AUTHOR	IZATION NUMB	ED				
			25.7111011710111011	IZATION NONE	LIT				
. A B C	4. L,	- I							
DATE(S) OF SERVICE To		E	F	G H	1 1	J	K		
01 01	(Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGES	OR Fami	IY EME	сов	ESERVED FOR LOCAL USE		
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	6. PATIENT'S ACCOUNT NO. 27. ACCEP	PT ASSIGNMENT? vt. claims, see back)	28. TOTAL CHARGE	29. AM	OUNT PAI	D 30.	BALANCE DUE		
FEDERAL TAX I.D. NUMBER SSN EIN 26	1234JED YES NO		s XXX XX s   s XXX XX						
FEDERAL TAX I.D. NUMBER SSN EIN 2	1201320		33. PHYSICIAN'S, SU	1	ING NAME	ADDRES			
SIGNATURE OF PHYSICIAN OR SUPPLIER 32	2. NAME AND ADDRESS OF FACILITY WHERE	SERVICES WERE !				.,			
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS		SERVICES WERE	& PHONE #				-,		
SIGNATURE OF PHYSICIAN OR SUPPLIER 32	2. NAME AND ADDRESS OF FACILITY WHERE	SERVICES WERE					-,		
. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	2. NAME AND ADDRESS OF FACILITY WHERE	SERVICES WERE	& PHONE #	g			-,		
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	2. NAME AND ADDRESS OF FACILITY WHERE	SERVICES WERE	& PHONE # I.M. Billing	g ams		8	7654321		